of the ethnic categories. Only 15.6% and 9.7% of the patients had lipid tests and LFTs within three months since the start of therapy. Non-Hispanic blacks were less likely to have lipid tests compared to non-Hispanic whites (OR = 0.804; 95% CI, 0.653–0.990). Presence of coronary heart disease (OR = 1.305; 95% CI, 1.093–1.556) and lipid test prior to the start of therapy (OR = 4.207; 95% CI, 3.607–4.908) were associated with an increased likelihood of lipid tests after the start of therapy. Older patients (OR = 0.987; 95% CI, 0.977–0.997) and non-Hispanic blacks (OR = 0.543; 95% CI, 0.413–0.713) had a lower likelihood of having LFTs than younger patients and whites. Presence of hypertension (OR = 1.312; 95% CI, 1.081–1.592) and prior LFTs (OR = 3.561; 95% CI, 2.939–4.315) were associated with an increased likelihood of LFTs after the start of therapy. **CONCLUSION:** Monitoring of lipid levels and adverse events for patients on statin therapy remains suboptimal. There exists an ethnic disparity in the management of hyperlipidemia.

PCV34

EFFECT OF CO-PAYMENT ON THE INITIATION OF STATINS AFTER CORONARY HEART DISEASE HOSPITALIZATION

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OBJECTIVES: To examine effect of co-payment on the initiation of statins after coronary heart disease (CHD) hospitalization. **METHODS:** Medstat Marketscan commercial and Medicare 1999–2002 databases including inpatient admission, outpatient and pharmacy claims were utilized for this study. The first CHD hospital admission was identified as the index hospitalization. The study sample consisted of adults who had no statin use during the year prior to the index hospitalization and had at least six-month follow up after discharge. The outcome was the initiation of any statin prescription during six-month follow up. Effect of co-payment on the initiation of statins was examined by a multiple logistic regression, controlling for age, gender, region, year of the index hospitalization, length of stay, baseline comorbidity, baseline number of drug therapeutic classes, and baseline non-statin lipid-lowering drug use. **RESULTS:** A total of 12,182 subjects met the inclusion criteria and were included in the analysis. Only 5411 (44.41%) had initiated statin therapy within six-months after discharge. Compared with those who had a co-payment less than or equal to $10, subjects with a co-payment over $20 were about two thirds less likely to initiate statin therapy (OR, 0.34; 95% CI, 0.29–0.39), while subjects with a co-payment between $10 to $20 were about 14% less likely. (OR: 0.86; 95% CI, 0.76–0.97). Other significant factors were baseline comorbidities including congestive heart failure, hypertension, diabetes, hyperlipidemia; baseline number of drug therapeutic classes, baseline non-statin lipid-lowering drug use, age, and year of hospitalization. **CONCLUSIONS:** Fewer than half the patients received statin therapy after CHD hospitalization. Co-payment appears to be a significant barrier to the initiation of statins, even after adjusting for other demographic and clinical variables.

PCV35

EFFECT OF CLINICAL PHARMACIST INTERVENTION ON LOW-DENSITY LIPOPROTEIN CHOLESTEROL (LDL-C) OUTCOMES IN AN AMBULATORY SETTING

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Many studies have shown that high serum concentrations of LDL-C are a major risk factor for coronary heart disease (CHD) and that lowering LDL-C levels will reduce the risk of major coronary events. Despite the availability of the National Cholesterol Education Program Adult Treatment Panel III (ATP III) guidelines for the management of hyperlipidemia, most patients do not achieve their target LDL goals. **OBJECTIVE:** To evaluate the impact of clinical pharmacist intervention on LDL-C outcomes, in patients at high risk of cardiovascular events. **METHODS:** Forty-six patients with clinical atherosclerosis, a disease that confers high risk for CHD events, under the age of 70 with LDL >110 mg/dL were identified from the data systems of Maccabi Healthcare Services (study group). The clinical pharmacist intervention consisted of meeting the physicians in order to present and discuss information regarding the ATP III recommendations on the management of hyperlipidaemia, and to go over patients clinical charts. Meetings were followed by written recommendations regarding LDL management and by periodic telephone follow-up to ensure implementation of the recommendations. Outcome analysis was based on a comparison between the study group and a control group (169 patients with similar characteristics). **RESULTS:** After 6-months follow-up 81% of the patients in the study group showed an improvement in LDL levels, with 24% achieving the ATP III goal for high risk patients of LDL <100 mg/dL. In the control group the numbers were 61% and 16% respectively. **CONCLUSION:** Results of several studies evaluating intervention programs indicate that pharmacists can play a key role in improving cholesterol management in lipid clinics, community pharmacies, or hospitals. This study demonstrates for the first time in Israel that clinical pharmacist can have a positive impact on meeting LDL-C goals and better treatment outcomes.

PCV36

CHOLESTEROL GOAL ATTAINMENT IN DYSLIPIDEMIC TREATED PATIENTS AND INCIDENCE OF CARDIOVASCULAR EVENTS IN CLINICAL PRACTICE

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OBJECTIVES: This study investigated in French primary care, the association between LDL-cholesterol goal attainment (LDL-C < 130 mg/dL in national guidelines) during three consecutive years and occurrence of cardiovascular events (CV) in multiple CV risk factor (three or more) patients, without coronary heart disease history. **METHODS:** A total of 579 patients treated with lipid lowering drugs (LLD) for three-years and with a yearly documented LDL-C (2000–2002) were consecutively included by 236 primary care physicians. Patients were classified into three groups according to the number of consecutive years they attained TO: all 3 years (TO+++: n = 145), only part of the time (TO intermediate: n = 256), and never (TO−−−: n = 178). CV risk factors and CV events (angina pectoris, myocardial infarction, heart failure, stroke, peripheral artery disease) occurring during the last year of observation, 2002, were retrospectively collected through computerized medical records (Thales database) and a specific questionnaire. The risk of occurrence of a CV events was studied according to TO status. Logistic regression model was used, to adjust for baseline differences in CV risk factors. **RESULTS:** Only 25% of patients reached TO during all three years. Patients with at least one CV event were 5.5%, 10.5% and 12.9% respectively in the TO+++, TO intermediate and TO−−− groups. Compared to TO+++, significantly increased risk of CV event was observed, both for TO intermediate (OR